

## REQUEST TO CHANGE REIMBURSEMENT

Office of Pharmacy Rates  
<http://maa.dshs.wa.gov/pharmacy>  
 Fax: (360) 725-1982

Telephone: 1-800-848-2842  
 Monday - Friday 9:00 a.m. to 12:00 p.m.  
 and 1:00 p.m. to 4:45 p.m.

**Please note:** You must transmit a claim prior to faxing this form.

PRICING CONFLICTS			
<input type="checkbox"/> Reimbursement less than cost	ACTUAL PER UNIT COST	AWP PER UNIT COST	WHO IS YOUR WHOLESALER?
<input type="checkbox"/> Availability Issue	WHEN WILL PRODUCT BE AVAILABLE?	WHO IS YOUR WHOLESALER?	
<b>NOTE: This form is <u>NOT</u> for dispense as written (DAW) requests for brand name. Please continue to submit those requests via fax to (360) 725-2141.</b>			
PATIENT INFORMATION			
NAME		PIC NUMBER	
PRESCRIBER INFORMATION			
PRESCRIBER NAME		DEA NUMBER	
PHARMACY INFORMATION			
NABP #	PHARMACY NAME	FAX NUMBER	TELEPHONE NUMBER
DRUG INFORMATION			
PRESCRIPTION #	DRUG NAME		NDC
DATE(S) OF FILL	QUANTITY	DAYS SUPPLY	
DIRECTIONS FOR USE (SIG)			
FOR DSHS/MAA STAFF USE ONLY			
<input type="checkbox"/> Form not complete or illegible. Unable to process request. Please complete and refax. <input type="checkbox"/> Unable to verify cost - please submit invoice. <input type="checkbox"/> Pricing for this claim has been corrected. Please reverse and rerun claim. <input type="checkbox"/> Request received. Verifying cost information. <input type="checkbox"/> Pricing on this NDC has been corrected - please reverse and rerun claim. <input type="checkbox"/> Denied. <input type="checkbox"/> Other:			
NAME OF CONTACT PERSON AT PHARMACY			OPR STAFF DATE

DSHS 13-753 (REV. 10/2005)

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